

TRANSCRIPT

LEGISLATIVE ASSEMBLY LEGAL AND SOCIAL ISSUES COMMITTEE

Inquiry into Early Childhood Engagement of CALD Communities

Sunshine—Monday, 25 November 2019

MEMBERS

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WITNESSES

Associate Professor Georgie Paxton, OAM,

Ms Meg Quartermaine, Coordinator, and

Ms Rachael Unwin, Sector Development and Policy Adviser, Victorian Refugee Health Network.

The CHAIR: Good morning. I officially declare the public hearing of the Legal and Social Issues Committee Inquiry into Early Childhood Engagement of Culturally and Linguistically Diverse Communities open. All mobile phones should be turned to silent. I welcome Associate Professor Georgie Paxton, OAM, from the Victorian Refugee Health Network. I believe two other presenters are here as well. Can I have you state your name and position for the record.

Ms QUARTERMAINE: Certainly. My name is Meg Quartermaine. I am the Coordinator of the Victorian Refugee Health Network.

Ms UNWIN: I am Rachael Unwin. I am the Sector Development and Policy Adviser at the Victorian Refugee Health Network.

The CHAIR: Thank you. All evidence taken by this Committee is protected by parliamentary privilege; therefore you are protected against any action for what you say here today. But if you go outside and repeat the same things, including on social media, those comments may not be protected by privilege. All evidence given today is being recorded by Hansard. You will be provided with a proof version of the transcript, and this will give you an opportunity to check it as soon as it is available. Verified transcripts, PowerPoint presentations or any handouts will be placed on the Committee's website as soon as possible. I invite you to proceed with a brief opening statement to the Committee, which will be followed up by questions from the Committee. Welcome.

Assoc. Prof. PAXTON: Thank you.

Ms QUARTERMAINE: Thank you to the Committee and the Chair for allowing us the opportunity to speak with you today. It is much appreciated. The Victorian Refugee Health Network was established in 2007. The network facilitates coordination and collaboration across the sector of health and community services. The objective of this is to provide and support service accessibility for those from refugee backgrounds, including those seeking asylum. We have an executive group that supports strategic direction and oversight into the activities. The network has provided expert advice over the years to a number of parliamentary select committees and committees at a federal and a state level.

Assoc. Prof. PAXTON: By way of additional background and just outlining my role, I am a general paediatrician by training, specialising in refugee health, and I have worked within the Royal Children's Hospital immigrant health service from 2005. Over that time our clinic has seen more than 17 000 attendances and we have trained a workforce of 37 paediatricians who remain largely connected with migrant health across metro and regional Victoria. Within that context there is certainly a background related to health, development and disability within the context of our submission.

In terms of the demographics, Victoria is a major humanitarian settlement state for people arriving as refugees and also for people seeking asylum, and Victoria has led in many areas of policy in this regard. There are significant numbers of refugee background children and families settling in Victoria. Of our annual intake nationally of around 18 750 people annually, 30 to 40 per cent of this number settle in Victoria. Putting numbers together, more than 51 000 people of refugee background have arrived in Victoria over the last decade, with 40 to 50 per cent aged under 18 years on arrival, so this is a very young population compared to the demography in Victoria. We had an additional intake over 2016–17 of 12 000 refugees from Syria and Iraq, and again around 40 per cent of this cohort settled in Victoria, predominantly in the LGA of Hume. At the moment there are at least 10 000 people seeking asylum in Victoria, including at least 1300 children aged under 18 years. It is worth noting that these communities also have children born in Victoria and born in Australia, and these are often large families.

Regional and rural settlement is increasing. For many years this has sat at around 10 per cent of the overall humanitarian intake that have moved to regional areas. That is projected to increase to between 15 to 19 per cent. This is also an area of active consideration by the network.

In terms of the submission by the refugee network, there are three key sections. Firstly, we consider early childhood engagement across the key ages and stages, including the intersection with maternal and child health services; early childhood education, including playgroups, child care and also access to formal kindergarten programs; and the early school years for children aged five to eight years. Could I comment that the

Committee's focus on zero to eight is welcome because too frequently we do not focus adequately on those early years and transition into formal schooling. We also review two important service areas for child health and wellbeing: those of early intervention for refugee background children with developmental delays or disability and also mental health services. Finally, we conclude by examining some key elements that have common ground across the services and systems, including social determinants of health, with a focus on housing and poverty; trauma-informed care; communication; cultural diversity; coordination; considering relationships; and supporting health literacy and also health system literacy, so both the individual's understanding of our health system but also our health system's understanding of the populations we serve. Finally, we conclude by mentioning data and measurement and how we might better be able to examine outcomes for these communities within Victoria. I might pause and I guess move to questions.

The CHAIR: We have heard from previous submissions and evidence the issue of the navigation. That seems to be a real challenge and barrier—the first initial step. With enrolment, we have heard about the online system. Most people of diverse backgrounds probably have challenges in relation to getting online. Do you think there is room to improve that first initial step?

Assoc. Prof. PAXTON: Yes. You raise a number of complex issues. I think it is probably worth providing some context and background. When people first arrive under our offshore refugee program they have settlement support for a period of around six months, which can be extended where there are complex medical or other issues. The early period of settlement is one of competing demands. People have moved countries, moved languages, moved contexts, moved cultures. Within that framework they have to find a house, they have to be supported to engage with Centrelink and the bank and the local community, to enrol children in school and/or kindergarten and to engage in English language classes for adults. At the same time they are trying to make sense of the immediate local environment, so it is this time of enormous change. On top of that we are linking people with the health system, and that is both primary care but often across the health system also linking with specialist care. All of those individual areas require navigation of service systems, and together it is indeed overwhelming. Case management supports people in those initial stages. However, on the ground that is less direct than it was years ago and there are genuine challenges in terms of all of those domains. If we add in situations where there are concerns about immediate health issues or disability or development, it is a whole range of additional service systems, including the NDIS. Together this is actually extraordinarily complex.

I think one of the key elements to emphasise is that for Victorian-born children we really have a stepped model of access to care. So if a child is born in this state and there are developmental concerns raised, perhaps through those early maternal and child health visits or by family or by community, people will step fairly gently through the service system, whereas if you arrive with complex health issues or complex disability you need everything at once, and that presents enormous challenges.

The CHAIR: So my follow-up question is: I note that in your submission you outlined deficiencies in the current data collection and reporting of culturally diverse and refugee-background populations, so I suppose can you just add on why is it so important to have the appropriate data and what can the Victorian Government do to improve the situation?

Assoc. Prof. PAXTON: So data and population measurement is perhaps one of my areas of interest, so feel free to also tell me to be quiet when the time arises. It is really important that we understand the communities we serve and that we can measure the impact of policies and policy development and understand if we are doing the right thing by children and by families. By way of background and also in full disclosure, I led a group which completed a report for the Victorian Government, which was actually published in 2011 but written over the period of 2008–10, and it was the *Refugee Status Report*. It actually still stands alone in that we have not repeated anything like this—the other jurisdictions have not completed this and internationally there are no comparable documents. What we did was look at all the administrative datasets within government and examine whether or not we could report on refugee-background communities. With that we were able to examine the health literature, the education participation. We could provide some information on kindergarten participation through using the census. We could examine housing and poverty and conditions and circumstances through the census information.

It gave us a picture which was in fact far more nuanced than perhaps we were expecting. In some areas refugee-background communities were facing very substantial disadvantage, notably in poverty, and these

communities were markedly more disadvantaged in terms of socio-economic status post-arrival. In other areas they actually had reasonably comparable outcomes, and some of those we were not expecting. That related to background parent education or skills people were bringing. That helps us understand how we might settle these communities better. They face a range of health challenges and a range of circumstances that may or may not lead to mental health problems, but at that point these communities were not able to access the mental health service system.

So through examining population data we can truly understand what is happening. For many years we have been advocating for a better understanding of refugee-background Victorians within our administrative datasets. There is a strong case clinically and in terms of implementing policy to examine country of birth, year of arrival, need for interpreter and preferred language. On top of that there is also a case for including an additional item number as to whether people arrived in Victoria as a refugee or seeking asylum. We had anticipated that data linkage, so linking one administrative dataset to another might help us examine some of those features, but to date that has not been a realistic viable option. It will be in years to come, but at the moment we are not able to examine those parameters. But we need to include all of our Victorians in our analyses of data. If nothing else, that would probably be the key recommendation from the network.

Ms SETTLE: I am a regional MP, and I am very interested in how you talk about the growth—we are looking at 19 per cent in the future—but also something that has come up in a few of the hearings that we have had is secondary migration. People are coming in as a refugee to Melbourne and then they move to Ballarat because it is a bit more of an open country lifestyle. You talk about entry into the MCH system—so they have arrived, they have got children, the birth has not happened in the hospital, so you are talking about exploring options. What sort of suggestions would you have? And I guess, extending into that secondary migration, how do we keep those people in the system?

Assoc. Prof. PAXTON: I think one of the key elements here is that the maternal and child health nurse 10 key ages and stages are really clustered in the first two years. Those visits are clustered in fact in the first 18 months, and then we have our 18-month, our two-year and our 3.5-year visits. If you arrive and you are aged older than two years and before five years you often do not have a great deal of contact with the maternal child health system, so that safety net of detecting kids where there are developmental concerns or providing immediate parenting support is often not present. I think with maternal and child health utilisation we know that actually participation rates for that three-and-a-half-year-old visit are in fact far lower than the participation rates for the earlier visits, particularly in the first 12 months; however, it is a real opportunity to connect with a primary care service system. Our suggestions would be basically naming refugee and asylum seeker communities as a priority group for the enhancement of the maternal and child health nurse service, and also prioritising linkage for those older preschool years, for the kids aged two to five. Oftentimes there are multiple children in a family, so it may be that the young children are linked, but let us look at all the kids zero to five and link them with this local system, because it opens doors into local government, it opens doors into immunisation and vaccination, it opens doors into navigating the health system and NDIS.

In terms of other key recommendations from the network's submission, there is complexity in terms of the early settlement period being one of mobility. People will frequently arrive and live in transitional housing for a period and often move LGA within weeks, and then some will move regionally or rurally within months or within the years after settlement, so we need better systems to link across those networks. But it is not just maternal and child health; this applies also to primary care, to specialist care, to NDIS and disability services.

The final one is actually to examine participation in maternal and child health, because data within the maternal and child health system has been difficult to examine for refugee background communities for many, many years. There were previous audits completed of maternal and child health participation which noted that there are challenges with the data we collect for CALD communities.

The CHAIR: Just one final question I had in relation to NDIS, in particular for refugee parents of children with a disability seeking appropriate support for their children and I suppose the impact of NDIS: what can be improved? We have heard that there have been so many gaps in this area, but from your perspective for the record what are some of the issues that can be improved?

Assoc. Prof. PAXTON: Firstly, by way of context, there are increasing numbers of refugee background Victorians with disability. This in part relates to changes to the migration law in 2012, which was in response to the joint standing committee on disability. The health requirement of the Migration Act was waived for humanitarian entrants, basically enabling people with disability to travel to Australia under Australia's offshore refugee program. In practice we probably did not see a great deal of change for two or three years, but from around 2016–17 we have seen relatively high numbers of new arrivals with disability. This is often complex disability and often disability which has not had adequate access to treatment or management, so it has got a greater functional impact than it might have had should the person have been born in Australia. So we have more people arriving with disability.

Refugee-background children have multiple risk factors for disability, and they are prenatal, perinatal and postnatal risk factors across a range of different health and environmental issues. So there are also additional risks as to why these cohorts may experience greater functional impairment. There is genuine complexity in assessing development for these children, and that is both for both young children but also for older children and adults. That relates to how we consider disability in the context of forced migration, in the context of language acquisition—people are moving countries, moving languages—in terms of not having that stepped diagnosis that you might have if you were born here.

With settlement and disability services, it is difficult to actually summarise the complexity, it is so great. The first thing is that early childhood intervention is difficult to access and there are long delays to access early childhood intervention. It is frequently not early and it is frequently not involving intervention. People need to go through a process of accessing and then planning and then getting approval and then engaging with services, all of which require substantial health system literacy. The consumer-driven approach of the NDIS is in many ways reinforcing inequities driven by social determinants of health, and at all stages of the NDIS people who are familiar with liaising with health professionals, who are familiar with how meetings run, who are familiar with navigating internet-based resources, in English predominately, who have an understanding of the health system and allied health system and who can advocate for their child—they are considerably advantaged.

In my own practice at the Children's Hospital I have three roles. I work within the general medicine unit and have a broad general paediatric practice. I am the paediatrician in the hearing impairment clinic, so I see all of the kids with hearing impairment. I also work predominantly in the refugee health space—and there are very substantial differences. Within the service system for the hearing-impaired kids, it is incredibly joined up and it works incredibly well. Kids are picked up early on screening, they are linked early with the service system and all parts of the service system combine to get kids and families into disability services where needed. We have early support coordinators, who help families experiencing disadvantage or families where there might be language proficiency issues, who are there to explain and support.

We do not have those same systems for kids of refugee background, and there are also geographic differences, particularly in the west, whereby NDIS access has been far more difficult and far slower compared to children who live in other inner metro areas, notably south and inner north. These inequities within the NDIS are an area that warrants substantial attention at the state level but also the federal level. I think the NDIS in itself is a wonderful thing. It is an amazing change and it will be phenomenal, but at the moment we actually need to have conversations about some of these barriers.

There are particular technical issues in terms of how NDIS is working. At the moment one of the challenges we are facing is that kids and families are being asked for diagnostic information for the young children, whereas by the NDIS funding guidelines that should not be occurring. You need a diagnosis 7 to 65 but not for the younger groups, and that seems to be causing delays and could be addressed at a state and federal policy level. The actual services themselves are a further area. You may get through NDIS in the west, which is oftentimes taking months or years, but then there may not be services to actually use your plan for at the other end. That is an area where we are seeing substantial geographic inequities and I would urge attention to. The other thing about the NDIS which is really complicated is that the NDIS has in many ways replaced alternative services. Previously the early intervention service was a level playing field in terms of access for all, but the NDIS residency requirements have had a substantial impact within my refugee and asylum seeker work and within the work of those in the network working with children. Initially there was additional funding announced by Vic State Government, and that was being basically administered by the Department of Education and

Training. That was then transitioned across to the early intervention partners, and since that time there have been enormous challenges in accessing that. There seems to be widespread confusion on the ground, and that is within the providers; the confusion for families is amplified.

It is worth mentioning finally that for children seeking asylum there are huge challenges to accessing early intervention services. They relate to residency, and they relate to accessing the suite of services that support childhood development. Not only is this related to direct intervention services; it is around access to child care, early support kinder and four-year-old kindergarten, all of which are really important developmental resources.

I should specifically commend the Victorian State Government for their leadership on free kindergarten for children who are refugees or children who are seeking asylum, because it has been amazing. It has made an enormous difference on the ground. I think universal three-year-old kinder is an additional and wonderful thing for these cohorts, and early support kinder has been an outstanding support for some of our children seeking asylum and some of our most vulnerable children.

The CHAIR: Just one final question. The Victorian Refugee Health Network recommends the process for developmental assessments of children be streamlined and incorporate a trauma-informed paediatric assessment. Can you expand on this recommendation? What are some of the requirements from the Victorian Government to achieve this?

Assoc. Prof. PAXTON: This relates to that concept of the fact that for Victorian-born children it is a stepped process of assessment. They will often come through screening, be picked up and be linked with the service system in a stepwise fashion. For kids arriving with developmental delays, disability or complex disability, they often need a whole range of supports immediately. It is around accessing those supports, particularly also in the school setting. When we assess kids developmentally—and this is an area of focus for the paediatrician workforce—we are looking at the elements of their development in relation to language acquisition, forced migration, family experience and prior education. We are examining whether there is a neurological, a genetic or a metabolic diagnosis as part of this, and we are examining whether there are any treatable components. All of this needs to happen, and it needs to happen quickly.

There are particular challenges for those children transitioning into school, particularly where kids have disability and it is clear that specialist education is an active consideration. We are absolutely acknowledging that parents have choice, but this is where we have kids with complex intellectual disability, with autism spectrum disorders or with complex physical disability. However, there is a waiting list to get those assessments and the assessment process in the school system is actually complicated. A child might arrive and clearly have an autism spectrum disorder, yet the waiting list to get a multidisciplinary team assessment might be two years. But we do not have two years to wait until they get into the school system. A lot of this work falls to the schools, and there are real complexities to how we get those assessments. If I have a child who arrives with a complex disability, who is in a wheelchair, who has a seizure disorder, who has problems with sensory impairment—visual impairment or hearing impairment—it is very clear that that child needs a range of different assessments. Yet we do not have a process for that child to easily get a cognitive assessment to gain access to specialist education, and in fact that is very confusing both for schools and for providers but definitely for families. On paper the assessment should be completed by a mainstream school, and if the child comes in at a certain level then they are able to access specialist education. However, if the child is not going to attend the mainstream school, then it is an additional financial and administrative burden on a mainstream school where they are trying to juggle the needs of their own students, and this system exposes gaps very, very quickly.

Where there are kids with substantial developmental difficulties or kids who had missed formal schooling, I would argue—and I guess this is a personal perspective, and a perspective formed within our service rather than an immediate network perspective—there is a really strong case to put in support funding for severely interrupted schooling with critical education needs, because the alternative at the moment is that we spend a huge amount of money on formal assessments which are not necessarily valid. So completing a cognitive assessment, completing a language assessment and completing audiology and formal vision assessment all carry a cost to the Victorian State system, yet if we have got a child who is eight and has not been to schooling previously, who has no literacy in their first language, they need supports and we can enable this better and more efficiently at a school-based system level.

That other thing to articulate really clearly for the Committee is attention to year-level placement. So within the Victorian education system we have a range of ages in any given classroom. Many children will start foundation level or prep level at five, but a large number of kids will actually start foundation or prep level at the age of six. So if we have a refugee-background child who arrives at the age of six, we should actively consider foundation as an alternative placement, not grade 1, because this kid not has not experienced prior Australian schooling or prior schooling in English. We can maximise their chances of success through careful consideration of grade placement. In part I say this because so frequently it goes wrong, and we have kids who miss levels. I have had kids who have been moved from prep to grade 3—we would not do that to a Victorian-born child—and we set them up to fail. We should think about this carefully and we can plan proactively. It is of no cost to the health system. It is in fact a cost saving and a gain for the health system.

The same goes for children who arrive when they are five. We should actively consider kindergarten. So there are children who are five who are doing a year of four-year-old kindergarten. It depends on when you are born, whether you are repeating and whether you have developmental delays, but we can proactively plan ahead. Kindergarten is not currently a key performance indicator of settlement, but there is an argument to join that system up with the federally-funded settlement program and to consider that kindergarten could become a KPI so we can enable kids to have the best start they can to formal schooling.

The CHAIR: Thank you very much for taking the time to present here today. The next stage will be that the Committee will deliberate on the evidence and submissions, and we will prepare a report next year with some strong recommendations to Government. The report will be handed down to the Legislative Assembly. If you would like to keep up-to-date with the progress of the report, you can go online to the Committee's website and keep updated with the progress. Again, thank you very much, and thank you for the that work you do.

Ms QUARTERMAINE: Thanks for your time.

Assoc. Prof. PAXTON: Thank you.

Witnesses withdrew.